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Aging & Mental Health
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/camh20

Lesbian, gay, bisexual and transgender older people in Ireland: Mental health issues

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Published online: 17 Jan 2013.

To cite this article: Edward McCann, Danika Sharek, Agnes Higgins, Fintan Sheerin & Michele Glacken (2013) Lesbian, gay, bisexual and transgender older people in Ireland: Mental health issues, Aging & Mental Health, 17:3, 358-365, DOI: 10.1080/13607863.2012.751583

To link to this article: http://dx.doi.org/10.1080/13607863.2012.751583

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Aging & Mental Health, 2013
Vol. 17, No. 3, 358–365, http://dx.doi.org/10.1080/13607863.2012.751583

Routledge
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Lesbian, gay, bisexual and transgender older people in Ireland: Mental health issues

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(*Received 20 June 2012; final version received 17 November 2012*)

International policy initiatives have highlighted the need to include older lesbian, gay, bisexual and transgender (LGBT) issues in the provision of appropriate health and social care. However, empirical studies in the area remain sparse. The aim of this study was to investigate the experiences and needs of LGBT people over the age of 55 years living in Ireland and this article reports on specific mental health issues. Mixed methods were used involving 144 surveys and 36 semi-structured in-depth interviews. The findings revealed that a significant number of the survey respondents had experienced a mental health problem at some point in their lives with interview participants providing further details of their concerns. It is recommended that policy makers address the mental health needs of older LGBT people in future strategic directives and develop standards of care that support the principles of equality, inclusion and respect for diversity.

Keywords: ageing; mental health; lesbian; gay; bisexual; transgender

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Introduction

As people are living longer and population statistics for older people are rising, policy makers and service providers are having to consider how best to respond in terms of future developments within health and social care (Brown, 2009; Fredriksen-Goldsen & Muraco, 2010; Hughes, Harold, & Boyer, 2011). Whilst some issues related to ageing may be similar for all older people, there is a growing awareness of the specific issues faced by older lesbian, gay, bisexual and transgender (LGBT) people (Age Concern, 2002; Equality Authority, 2002; Knocker, 2012). One of the key priorities indentified in the *Burning Issues* report of the National Lesbian and Gay Federation in Ireland concerned increasing support to older LGBT people (Denyer, Howard, McEvoy, & Ó hUltacháin, 2009). Additionally, the *National Positive Ageing Strategy for Ireland* highlighted the need for the recognition and incorporation of older LGBT people's needs into the strategy (Office for Older People, 2010). Although there appears to be positive advances towards equality for LGBT people in Ireland, challenges still exist. Research highlights that LGBT people of all age groups are subjected to ongoing prejudice and discrimination in all areas of life (BeLonG To, 2005; Equality Authority, 2002; Gibbons, Manandhar, Gleeson, & Mullan, 2007; Layte et al., 2006; Mayock, Bryan, Carr, & Kitching, 2009; Norman, Galvin, & McNamara, 2006). Given the historical context of LGBT people's lives, it is understandable that the concerns of older LGBT people about finances, health, and loss of independence or mobility are set against the backdrop of fears of discrimination and further exclusion should they need to access health or social services (Hughes, 2009). Older LGBT people have repeatedly aired their fears that such discrimination will be evident within existing health and social services, including mental health services (Fish & Bewley, 2010; Jackson, Johnson, & Roberts, 2008; Johnson, Jackson, Arnette, & Koffman, 2005; Mays & Cochran, 2001). Furthermore, transgender people who are older remain even more invisible in terms of accessing appropriate and responsive services (Grant, Mottet, & Tanis, 2011). This study entitled *Visible Lives* (Higgins et al., 2011) investigated the health and social care needs of LGBT people over the age of 55 years living in Ireland and this article reports on the findings related to mental health.

Current literature

A majority of the existing studies into older LGBT people's lives have been conducted in the USA, Australia and England. The situation in Ireland has rarely been discussed.

Adjustment to ageing

Available research has challenged the negative stereotype of older LGBT people as unhappy, isolated and celibate (Hughes, 2008; Orel, 2004; Woolf, 2000). Studies show that there is wide variety of life course trajectories and attitudes to ageing that are influenced by gender identity, sexual orientation, coming out histories, marital status and friendship networks (Heaphy, Yip, & Thompson, 2004; Hughes et al., 2011; Schope, 2005). Parallels may be drawn between factors that may affect ageing in LGBT populations

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and those experienced by heterosexual people. Similar to the heterosexual population, self-acceptance, having a purpose in life, the presence of a life partner and financial security are all predictors of good quality of life for older LGBT people (Haber, 2009; Landers, Mimiaga, & Krinsky, 2010). However, some studies demonstrate that older LGBT people adjust to ageing more successfully than their non-LGBT counterparts (Bradford, Ryan, & Rothblum, 1994; Brotman, Ryan, & Cormier, 2003; Orel, 2004). The term 'crisis competency' has been used to describe how the stress and challenges of the 'coming out' process may buffer LGBT people against later crises (Kimmel, 1978). Other theorists assert that in contrast to the older heterosexual population who have not previously come across active discrimination, older LGBT people have become adept at dealing with prejudice, stigma and loss throughout their lifetime (Gabbay & Wahler, 2002; Jones & Nystrom, 2002). As a consequence, older LGBT people have developed a range of coping mechanisms to deal with discriminatory experiences and environments (Jones & Nystrom, 2002; Schope, 2005; Woolf, 2000). In terms of this resilience, studies have demonstrated the strengths that LGBT people may bring to the ageing process. Some of the recognised attributes include increased tolerance, the creation of families of choice and greater flexibility in gender roles (Berlin, 2008; Dorfman et al., 1995; Healey, 1994; Jones, 2001). Additionally, researchers have reported higher levels of life satisfaction, lower self-criticism and fewer psychosomatic problems among older LGBT people (Barranti & Cohen, 2000; Humphreys & Quam, 1998). A recent Irish study identified important sources of social support in relation to resilience including connectivity with friends, family, LGBT communities, and workplace environments (Mayock et al., 2009).

Social exclusion

Older adults, LGBT or heterosexual, may be perceived as an invisible group in a western culture that emphasises youth, physical beauty and economic productivity (McGlone & Fitzgerald, 2005). According to Genke (2004), if a person is older and LGBT, a 'double invisibility' may exist. Older LGBT people may be considered an 'invisible minority within a minority' (Health Service Executive, 2009), and be 'hidden or forgotten' within research studies (Crisp, Wayland, & Gordon, 2008). This invisibility may be attributable to many causes including the historical context of older LGBT people's lives. In Ireland, homosexuality was perceived as an illness, judged as sinful and considered unlawful; homosexual acts between consenting male adults above 17 years of age were not decriminalised until 1993. As a result, many LGBT people living in Ireland were raised in an environment where they were subjected to heterosexism, homophobia and exclusion (Barrett, 2008; Knauer, 2009; Slusher, Mayer, & Dunkle, 1996). Other possible consequences included employment discrimination, disempowerment and estrangement from family and community (Health Service Executive, 2009; Hughes, 2009; Kimmel, Rose, Orel, & Greene, 2006; Phillips & Marks, 2008). Many LGBT people, for safety and economic reasons, hid their sexual orientation and gender identities (Knauer, 2009; Rivers, McPherson, & Hughes, 2010; Stotzer, 2009). Concern has also been expressed about the invisibility of older LGBT people in the health and social care sector, which may be due in part to the heteronormative assumptions made by service providers, the treatment of sexuality as a private matter and the perceptions that older people are perhaps asexual (Bayliss, 2000; Hughes et al., 2011). This may result in older LGBT people experiencing barriers when accessing appropriate healthcare services (Health Service Executive, 2009).

Mental health and emotional well-being

Whilst many LGBT people have learned to adjust to society's prejudices and have developed positive coping strategies, tensions exist between their needs and experiences that can result in minority stress. The concept of minority stress is based on the premise that LGBT people may experience enduring psychological stress due to their stigmatised and marginalised status (Meyer, 2003). Nevertheless, there is still limited data on the specific mental health needs of older LGBT people (Health Service Executive, 2009). However, existing studies reveal links between minority stress, emotional distress and mental health problems in the general LGBT population (Health Service Executive, 2009; King et al., 2008; Kuyper & Fokkema, 2009; Meyer, 1995). King et al. (2008) completed a meta-analysis of 25 studies that investigated mental disorder, suicide and self-harm in LGB people. Results indicated a twofold increase in suicide attempts and significantly higher rates of depression, anxiety disorders and alcohol dependence among LGB participants. The study demonstrated that lesbian and bisexual women were particularly at risk of substance misuse, whilst lifetime prevalence of suicide attempts was especially high in gay and bisexual men. In a study on suicide risk among transgender people, 41% of transgender men and 20% of transgender women reported suicide attempts (Maguen & Shipherd, 2010). A recent Irish survey found that 86% of the LGBT respondents experienced depression, 25% were taking prescribed medication and 27% indicated that they had self-harmed at least once (Mayock et al., 2009). Other studies show increased rates of mental health problems for LGBT people related to societal oppression, stigma, homophobic bullying and the use of alcohol and drugs as a means of coping (Farquhar, Bailey, & Whittaker, 2001; King & McKeown, 2003; Robertson, 1998). Additionally, LGBT people may have to endure

the twofold stigma associated with a mental health issue and their sexual orientation (National Disability Authority, 2005). LGBT people may also be subjected to hate crimes and violence that may significantly increase a person's susceptibility to developing a mental health problem (Casey et al., 2006; D'Augelli & Grossman, 2001; Meyer, 2003). Loss and grief can also have a significant impact on mental health, particularly if the grief is unacknowledged (Glacken & Higgins, 2008).

Methods

Study design

This exploratory study used a mixed methods approach where both qualitative and quantitative data were gathered through surveys and interviews. Because of the sensitive nature of the research and the potential difficulties of reaching participants, the survey method was adopted as it allowed the researchers to reach as many people as possible and assured the complete anonymity of participants. Interviews complemented the survey data by facilitating a more in-depth exploration of participants' subjective experiences and views.

Aim and objectives

The overall aim of the study was to investigate the experiences and needs of LGBT people over the age of 55 years living in Ireland. The objectives were to examine the lives of participants, highlight positive and negative experiences, describe service use, and determine recommendations in terms of policy, practice and future research.

Sampling and inclusion criteria

Inclusion criteria included identifying as LGBT, being over 55 years of age and currently living in the Republic of Ireland. A non-probability sampling technique was used and a purposive sample of participants who had completed the survey was interviewed.

Demographics

The key characteristics of the survey respondents ($n = 144$) and the interview participants ($n = 36$) are provided in Table 1. The mean age of both the survey respondents and interview participants was 60 years.

Survey

The survey instrument used was developed from previously established surveys and by the research team. The instrument was piloted and the final version contained 84 questions related to demographics, life experiences, sexual orientation and gender identity, health and well-being, service experiences and mental health issues. In order to improve the accessibility of the survey, it could be completed online via a dedicated website, by post or by telephone. Respondents were recruited through a wide variety of relevant organisations, groups and through press advertisements. Recruitment packs were posted to 80 organisations and information was also sent electronically. A total of 144 people completed the anonymous survey.

Table 1. Demographics of the survey and interview samples.

Variable	*N* (%) Survey ($n = 144$)	*N* (%) Interview ($n = 36$)
Age (years)		
55–59	85 (59)	22 (61)
60–64	34 (24)	9 (25)
65–69	17 (12)	3 (8)
70–74	6 (4)	2 (6)
75–79	1 (>1)	0 (0)
80+	1 (>1)	0 (0)
Gender identity		
Male	93 (65)	22 (61)
Female	39 (27)	11 (31)
Transgender	10 (7)	2 (6)
Other	1 (>1)	1 (3)
Missing	1 (>1)	0 (0)
Sexual orientation		
Gay	87 (61)	22 (61)
Lesbian	28 (20)	13 (36)
Bisexual	13 (9)	1 (3)
I do not usually use a term	9 (6)	0 (0)
Heterosexual	3 (2)	0 (0)
Other	3 (2)	0 (0)
Missing	1 (>1)	0 (0)

Interviews

Respondents who completed the survey were invited to take part in a semi-structured in-depth interview. All people who completed and returned an expression of interest form by a specified date were offered an interview. The interview guide was developed in order to learn more about people's experiences and perceptions of being an older LGBT person in Ireland. Specific questions addressed mental health status, suicide and self-harm, substance misuse, violence, and grief and loss. Each interview was conducted at a time and location convenient to participants. At the beginning of the interview, people were assured confidentiality, informed of their right to stop the interview or not to answer any questions if they so wished, and their right to request any aspect of the recording be deleted if they did not wish it to be used in the study. The sensitivity of the topic was appreciated and particular attention was paid to supporting people if they became emotionally upset. The researchers who conducted the

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interviews consisted of three mental health nurses and a social science researcher, all experienced in qualitative interviewing. They were aware that by fostering a relationship of mutual trust and respect that participants would comfortably convey their thoughts and feelings on the topic (McCann, 2010). Each interview was tape recorded and lasted between 60 and 90 minutes. In all, 36 interviews were conducted.

Ethical issues

Ethical approval to conduct the study was received from the Research Ethics Committee of the University Faculty of Health Sciences. Participants provided signed consent. All of the interviews were carried out face-to-face. Anonymity was guaranteed and all data were stored securely.

Data analysis

The quantitative data were analysed using SPSS (version 17). Descriptive statistics were used to address the study objectives. All face-to-face interviews were tape recorded and transcribed verbatim. The computer software package, NVivo 8, was used to assist in the organisation, management and retrieval of the qualitative data. The data were coded, examined and compared for meaning. Relevant codes were combined to form higher order codes. This constant comparative process continued until a number of major categories emerged. Finally, the interview findings were reviewed in light of the survey results that would allow for a deeper understanding of pertinent issues.

Study results

Mental health status

One-third of the survey respondents (33%; $n = 44$) reported having experienced a mental health problem at some point in their lives. Approximately, one in 10 (11%; $n = 15$) of the survey respondents were currently taking prescribed medication, suggesting that the mental health problem was ongoing. Other mental health problems listed by respondents were drug addiction, anorexia nervosa, bipolar disorder and gender identity disorder. Although some survey respondents related their mental health problem to a 'fear of gay life', others suggested that it was 'associated with other past experiences', including childhood abuse, being in a violent relationship, loss and bereavement, as well as stresses related to family ill health, work and finances.

Suicide and self-harm

One in 10 survey respondents (11%) reported that they had seriously thought about ending their life and one reported a suicide attempt in the past year. In the previous 12 months, 4% ($n = 6$) reported that they had self-harmed. In many cases, interview participants' distress was associated with their struggles to come to terms with their LGBT identity in a society that was discriminating and alienating or with the loss of a relationship as a consequence of their disclosure:

> I believe because I was suicidal, it's not because of my gender identity disorder. It was because of the disorder of society not accepting me. (Lesbian Female, Gender Identity Disorder, 58 years)
> Inside I was dying and, in fact, every night before I went to bed I'd always put all my books and stuff in order and then I'd ask God to take me in my sleep.... life was so painful. (Lesbian Female, 58 years)

Substance misuse

The prevalence of alcohol use for the survey sample was 83%. Fourteen percent ($n = 19$) reported that they 'worry about drinking too much' and seven respondents indicated that their mental health issue was related to alcohol. Some expressed concern about what one participant described as the 'appalling amount of alcohol consumed on the gay scene in Ireland' (Gay Male, 59 years). One woman who had married and come out later in life commented on the rates of alcohol use among the lesbian community:

> I met a lot of gay women and I was absolutely shocked at the state of them. I ended up thinking to myself, 'Jesus Christ, I made the right decision' [marry and not come out until later]...You never get it right but I wouldn't have preferred to have been an alcoholic and feeling such low self-esteem that these women were feeling. (Lesbian Female, 59 years)

Some respondents recalled how they used alcohol to help them cope with issues related to gender identity and sexual orientation. One person spoke of the detrimental effects of alcohol on their relationships:

> I wouldn't be confident enough. So I'd have to have five or six pints, and it was all around that that I became an alcoholic, and I would also probably think with breakdown of friendships and relationships [sexual], it was all down to drinking... (Gay Male, 56 years)

One person spoke of using alcohol to ease the process of coming out 'I needed the few jars in me when I did tell people' (Gay Male, 61 years). Others spoke of using alcohol in order to deal with painful emotions:

> I found myself drinking a lot, drinking quite a lot. I was dependent...I felt if I drank enough that I would block out all these things that I didn't want to be in my head. I would drink on my own. I would go into the small bar...sit and feel myself slowly getting drunk and going home. (Gay Male, 57 years)

Six survey participants (4%) reported using illicit drugs recreationally within the last year, with four of these reporting having done so in the preceding month.

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Experiences of violence

Nearly half (47%) of the survey respondents reported being verbally insulted and 19% reported being punched or kicked on the basis of their LGBT identity. One-quarter (25%) had been threatened with physical violence and one-fifth (20%) had people threaten to 'out' them. A further 16% experienced domestic or partner violence in their relationships and 7% of participants reported experiencing sexual violence. Six of the participants interviewed also spoke of experiencing some form of physical and sexual violence, including stranger and date rape. One man who had been sexually assaulted had not reported it to the authorities or told any of his family:

> I said, 'How could I even begin to tell them what had happened to me?' Block it; it's gone. Forget about it. (Gay Male, 57 years)

Grief and loss

Nearly one in 10 (9%) of the survey respondents reported surviving the death of a partner or spouse of the same sex. One in four (25%) of the survey respondents and 10 of the interview participants were divorced or separated from a person of the opposite sex. Some of the interview participants highlighted the disenfranchised nature of their own grief and the grief of other LGBT people who had experienced the death or separation from a same-sex partner. One woman, after separating from her husband, had a relationship with an older widowed woman with children who subsequently died:

> But it can be tough at times. The only way I could cope with it was get away into my own place at night [lives on her own], away from everyone. (Lesbian Female, 59 years)

Within the study, some of the male participants spoke of the intensity of the losses experienced as a consequence of AIDS and its impact on them:

> ...The cream of Irish homosexual men was wiped out... It started when I was 30 I suppose and it's gone on since then. (Gay Male, 59 years)

The impact of suicide on the LGBT community was also an issue that was raised by some participants:

> By the time he [friend] had committed suicide he had cut himself off from everybody... The other person was younger... Out of the blue he just hung himself and nobody had any explanation... no explanations. (Gay Male, 55 years)

Of the 11 interview participants who had married a person of the opposite sex, 10 were now either divorced, separated or had had their marriage annulled. One person described the emotional reaction:

> So that was very traumatic for her, terribly traumatic for her. Fairly traumatic for me but I had been expecting it for a while... I know I hurt my wife, my ex-wife. I know I hurt her and I think my sons to a certain degree were quite worried about it as well, although now they totally accept it. (Gay Male, 56 years)

For many participants grief was also experienced during the coming out process because of the subsequent rejection by parents, siblings and spouses. In addition, some participants initially experienced rejection from their children.

Limitations

Whilst this study illuminates important issues related to mental health, the findings must be considered in the context of the following limitations. The findings are based on a non-probability sample of older LGBT people and it is unlikely that the sample is statistically representative of all older LGBT people in Ireland. People self-identified as LGBT and self-selected to participate in the survey and interview and this may bias the sample towards people who are secure in their sexual orientation and gender identity. Furthermore, women and people over the age of 70 years of age are underrepresented in the samples.

Discussion

Whilst many participants described having experienced low points in terms of their emotional well-being, the majority of survey participants considered their mental health to be good. This may be related to positive coping strategies and resilience developed over time (Jones & Nystrom, 2002; Schope, 2005; Woolf, 2000). One-third of the survey respondents reported having experienced a mental health problem at some point in their lives and 1 in 10 (11.1%) were currently taking prescribed medication, suggesting an ongoing mental health issue. Although not directly comparable, this figure is slightly lower that findings from a 2008 Irish study that found 19.9% of people aged 50–64 years and 11.2% of over 65 years old had experienced a mental health problem in the previous year (Tedstone Doherty, Moran, & Kartalova-O'Doherty, 2008). Similar to the findings from other studies, the most frequently reported mental health problem was depression and anxiety (King et al., 2008; Mayock et al., 2009). The reported incidences of self-harm and suicide attempts in the survey were relatively low (11.4%) compared to another study of LGBT people in Ireland where 52% of respondents had seriously thought of ending their life and 27% had self-harmed (Mayock et al., 2009). Furthermore, the qualitative findings suggest that participants' self-harming behaviour was associated with their coming to terms with their LGBT identity in a society that was discriminating and alienating. Substance use and misuse was also explored, with participants' narratives supporting much of the prevailing literature around substance use among LGBT people (Farquhar et al., 2001; King & McKeown, 2003; Robertson, 1998). Several interview participants explained how alcohol became a

means for coping with difficulties in coming to terms with being LGBT. The findings for illicit drug use (5%) are also higher than the 0.5% illicit drug use reported among those aged 55–64 years in the general population in Ireland (National Advisory Committee on Drugs and Drug and Alcohol Information and Research Unit, 2005). Despite advances in equality legislation, findings indicate that LGBT people are still experiencing violent or threatening situations on the basis of their identity. Older LGBT people are exposed to higher incidences of violence and abuse when compared to the older general population. Within this study, one-quarter of the survey sample had been threatened with physical violence and one-fifth had been punched or kicked or had people threaten to out them. Domestic and partner violence was also an issue for 15% of participants and 7% of participants reported experiencing sexual violence. These findings are comparable to those reported in other LGBT studies (Gleeson & McCallion, 2008; Mayock et al., 2009). Throughout their lives, many of the participants in this study experienced multiple losses. Similar to other studies that highlighted the nature of disenfranchised grief within the LGBT community (Glacken & Higgins, 2008), participants within this study also described incidents where their grief and loss went unrecognised and unacknowledged by family, friends and the wider community.

Conclusion

Older LGBT people living in Ireland have grown up in a culture where their sexual identity was considered criminal, pathological and sinful. This has resulted in invisibility in terms of policy developments, service provision and research around older LGBT people's needs. However, this study reveals many important mental health issues and concerns for older people who are LGBT. The information should help guide mental health policy makers in the creation and development of more inclusive and responsive mental health care provision. There is a need for policy makers to address the mental health needs of older LGBT people in future strategic directives. This will involve capacity building work with mental health service providers and the establishment of standards of care that embrace the principles of equality, inclusion and respect for diversity. Health and social care practitioners should have access to training on sexual orientation and gender identity relating to the care of older LGBT people. Furthermore, there remains a distinct lack of national and international research that specifically addresses the needs and aspirations of older LGBT people, particularly women, people over 70 years of age and LGBT people living in care homes. Future research should be adequately funded and older LGBT people should be fully involved in future policy and practice developments.

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